

Michigan Cancer Surveillance Program

April 2012 Update

Michigan Cancer Surveillance Program Web Page ~

To download this or previous issues of the MCSP Updates, Cancer Report Form, Cancer Program Manual, MCSP Site-Specific Factor (SSF) Fields for Collaborative Staging (CS) Version 02.03, or the MCSP Reporting Requirements by Item and Facility Type – December 2011, go to http://michigan.gov/mdch/0,4612,7-132-2945_5221-16586--,00.html.

For future reference, you may want to save this link as a favorite and rename it as ‘Michigan Cancer Surveillance Program.’

Michigan Abstract Plus Users ~

The version of Abstract Plus needed to process NAACCR version 12.1 records, which is required for cases with a diagnosis date of January 1, 2011 and forward, is expected to be finalized and distributed to Michigan Abstract Plus users by the end of this month.

Any outstanding cases diagnosed 2010 and earlier not submitted prior to April 1, 2012 must be submitted in the upcoming revised version of Abstract Plus, NAACCR version 12.1.

Submission of Data ~

Some important reminders regarding submission of data are listed below!

- The contact person for submission of cancer data disks is still Wendy Stinnett at (517) 335-8747 or StinnettW@michigan.gov
- METRIQ and ONCOLOG software users can submit data using NAACCR version 12.1 and 12.2

Change in Coding – “Scope of Regional Lymph Node Surgery” ~

Clinical investigators working in collaboration with staff at the National Cancer Data Base raised concerns regarding the validity of reported data describing the type of regional lymph node surgery performed for patients undergoing breast cancer operations. Multiple agencies/organizations, including the American College of Surgeons Commission on Cancer (CoC), National Cancer Institute’s Surveillance Epidemiology and End Results (SEER) program, the Centers for Disease Control and Prevention’s National Program for Cancer Registries (NPCR), and NAACCR concluded that sentinel lymph node biopsies for breast cancer have been significantly under-reported using current coding instructions for the data items RX Hosp--Scope Reg LN Sur (NAACCR Item # 672) and RX Summ--Scope Reg LN Sur (NAACCR Item #1292).

A report was written that includes a description of the origin and scope of the problem, plans from each agency to address the issue, and ***revised coding directives to be used for cases diagnosed January 1, 2012 and later.***

To download a copy of this report and the new coding directives, go to the ACS website at <http://www.facs.org/cancer/coc/fordsmanual.html> and click on the link Change in Coding “Scope Regional Lymph Nodes Surgery” (60K PDF) 3/13/12.

Educational opportunities will be provided by the different agencies in the later part of 2012.

In-house Edits ~

When we were preparing for the Call for Data to NAACCR in March of 2012, we came across several errors that were consistent throughout the data.

TEXT FIELDS

As high-quality text documentation facilitates consolidation of information from multiple reporting sources at the central cancer registry, it is extremely important for information to be entered and recorded properly into the text fields. When recording text, it may be helpful to remember that the abstract should be able to be re-abstracted from the information entered into the various text fields.

Text fields must contain a description that has been entered by the abstractor independently from the code(s). Information documenting the disease process and treatments provided (clinical/histological diagnosis, dates, scopes, x-rays/scans, laboratory, surgical procedures, number of lymph nodes removed, number of lymph nodes positive, number of lymph nodes negative, residual disease, LVI, etc.) should be entered manually from the medical record. Be specific as possible. For example, in the Surgery Text Field you must record the date of the procedure AND the name of the surgical procedure.

Suggestions for text are as follows:

- Date of physical exam
- Age, sex, race/ethnicity
- History that relates to cancer diagnosis
- X-rays, scans and other imaging examinations that provide information about the tumor and/or staging of the tumor being reported
- Histology
- Tumor size
- Palpable lymph nodes
- Record positive and negative clinical findings; record positive results first
- Impression (when stated and pertains to cancer diagnosis)
- Treatment plan
- First course of treatment (dates and types of each)

Detailed instructions for Text fields are included in the NAACCR Volume II Data Dictionary at <http://www.naacr.org/StandardsandRegistryOperations/VolumeII.aspx>.

COMORBIDITIES AND COMPLICATIONS

Depending upon whether the hospital has implemented the use of ICD-10-CM codes, the information regarding the patient's preexisting medical conditions may be recorded using *either* ICD-9-CM or ICD-10-CM codes. When recording this field

- Do NOT mix ICD-9-CM and ICD-10-CM codes
- Verify that the codes are within the range and a valid code

For more information, refer to the Facility Oncology Registry Data Standards (FORDS) at <http://www.facs.org/cancer/coc/fordsmanual.html>.

INPATIENT STATUS

Please review the following coding instructions for Inpatient Status, NAACCR Item 605, which is effective for cases diagnosed January 1, 2010.

- **Use code 0** if the patient was never an inpatient (at the reporting facility) AND leave the Inpatient Admit Date and Inpatient Discharge Dates blanks AND code the Inpatient Admit Date and Inpatient Discharge Date Flags to 11 (patient was never an inpatient at the reporting facility).
- **Use code 1** if the patient was an inpatient (at the reporting facility) AND enter valid dates in the Inpatient Admit Date and Inpatient Discharge Date fields AND leave the corresponding Flag fields blank.
- **Use code 9** if unknown if the patient was an inpatient (only used for consolidated cases) AND leave the Inpatient Admit Date and Inpatient Discharge Date fields blank AND record the corresponding flag fields to code 10 (unknown if patient was an inpatient).

For more information on Inpatient Status and the Inpatient Admit Date and Inpatient Discharge Date fields, refer to the coding instructions included in FORDS at <http://www.facs.org/cancer/coc/fordsmanual.html>.

B-CELL CHRONIC LYMPHOCYTIC LEUKEMIA/SMALL LYMPHOCYTIC LYMPHOMA

For instructions on how to code the primary site for a diagnosis of B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma, refer to the 2010 Hematopoietic and Lymphoid Neoplasm Case Reportability and Coding Manual, rules PH9 and PH10. The Hematopoietic Database version 1.6.3 (includes coding manual) can be downloaded at <http://www.seer.cancer.gov/tools/heme/index.html>.

PH9: Is the diagnosis B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma (BCLL/SLL) and peripheral blood is involved (the bone marrow may also be involved)?
Code the primary site to bone marrow (C42.1) and the histology as BCLL/SLL (9823/3).

PH10: Is the diagnosis B-cell chronic lymphocytic leukemia/small lymphocytic lymphoma AND you cannot verify that the disease originated in the bone marrow?

Code the primary site to the lymph node region (C77.0 – C77.9), tissue or organ and the histology as small B-cell lymphocytic lymphoma (9670/3).

NOTE: It is extremely important to document the findings of involvement, i.e., peripheral blood, tissue, organ, lymph nodes and/or bone marrow in the appropriate text field in order for the MCSP staff to determine the validity of the primary site and histology codes.

LYMPH-VASCULAR INVASION

Issues with the coding of the lymph-vascular invasion (LVI) have been identified and are as follows:

- LVI cannot be left blank
- Improper use of codes based upon primary site, morphology, and/or cell behavior
- Lymphatic invasion is not the same as involvement of regional lymph nodes
- Lymph-vascular invasion does not include perineural invasion
- Vascular invasion is not the same as direct tumor extension from the primary tumor into adjacent blood vessels

The description, definition, coding instructions and use of codes for LVI are included in the Collaborative Staging Manual (CS), General Instructions, Part 1, Section 1 at <http://www.cancerstaging.org/cstage/manuals/index.html>.

The codes and the use of codes are as follows:

CODE	DESCRIPTION
0	Lymph-vascular invasion not present (absent)/Not Identified
1	Lymph-vascular invasion present/identified
8	Not applicable
9	Unknown if lymph-vascular invasion present/Indeterminate

- **Use code 0** when the pathology report indicates there is no lymph-vascular invasion. This includes cases of purely in-situ carcinoma, which biologically have no access to lymphatic or vascular channels below the basement membrane.
- **Use code 1** when the pathology report or a physician's statement indicates that lymph-vascular invasion (or one of its synonyms) is present in the specimen.
- **Use code 8** for the following primary sites.
 - Hodgkin and Non-Hodgkin lymphoma
 - Leukemias
 - Hematopoietic and reticuloendothelial disorders
 - Myelodysplastic syndromes including refractory anemias and refractory cytopenias
 - Myeloproliferative disorders

- **Use code 9 when**

- There is no microscopic examination of a primary tissue specimen
- The primary site specimen is cytology only or a fine needle aspiration
- The biopsy is only a very small tissue sample
- It is not possible to determine whether lymph-vascular invasion is present
- The pathologist indicates the specimen is insufficient to determine lymph-vascular invasion
- Lymph-vascular invasion is not mentioned in the pathology report

MCSP Staff ~

If you have any questions regarding cancer reporting, or would like more information about workshops, please feel free to give one of us a call.

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NOTE! Some e-mail addresses have changed. If you have not already done so, please update your address book at this time.